Bureau of Health Care Quality and Compliance

			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
					<u> </u>		04/04/0044		
		NVN2117AGZ				01/	24/2011		
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA					
EMERITU	S AT THE SEASONS		5165 SUMMIT RIDGE CT RENO, NV 89523						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
Y 000	Initial Comments			Y 000					
Y 105	Initial Comments  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 1/18/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 120 Residential Facility for Group beds, Category II: 79 for elderly and disabled persons, 11 beds which provide assistelliving services and 30 beds for persons with Alzheimer's disease. The census at the time of the survey was 58. Fifteen resident files were reviewed and 15 employee files were reviewed. One discharged resident file was reviewed.  The facility received a grade of B.		d as das das das das das das das das das	Y 105					
SS=D	449.200(1)(1) Person	nel File - Background C	леск	1 105					
	a separate personne member of the staff of	se provided in subsection I file must be kept for ea of a facility and must inc Iiance with NRS 449.17	ach lude:						
	This Regulation is no	ot met as evidenced by:							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING		COMIT EL TES			
		NVN2117AGZ		B. WING		01/	24/2011		
		NVNZTITAGZ	CTDEET ADD	<b>I</b> RESS, CITY, STA	ATE ZID CODE	017.	24/2011		
EMERITU	S AT THE SEASONS			5165 SUMMIT RIDGE CT RENO, NV 89523					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORE		(X5)		
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE		
Y 105	Continued From pag	e 1		Y 105					
	failed to ensure 1 of background check re to 449.188 (Employe	equirements of NRS 449 ee #12).							
	Severity: 2 Scope:	ı							
Y 255 SS=F	449.217(6)(a)(b) Per on Food Service	mits - Comply with NAC	446	Y 255					
	chapter 446 of NAC. (b) Obtain the necess	standards prescribed in							
	Based on observation review on 1/18/11, the	ot met as evidenced by: n, interview and record ne facility failed to ensur n the standards of NAC	e the						
	Findings include:								
	1 Critical Violations:								
	found spoiled in the	dy-to-eat light tuna fish odry storage room. A tead the tuna fish to room							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED . 01/24/2011	
	NVN2117AGZ						
				<b>I</b> RESS, CITY, STA	TE, ZIP CODE	01/2	4/2011
			5165 SUMN RENO, NV	IIT RIDGE CT 89523			
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Y 255	Continued From page 2			Y 255			
	temperature for appro	oximately six days.					
	2. Cleaning and Sani	tation Issues:					
	a. A 'ziplock baggy' o properly labeled in the	of cooked chicken was i e walk-in refrigerator.	not				
	b. The ice scoop was	s not properly stored.					
	c. The following food contact surfaces were soiled with food and kitchen debris: the deli slicer blade sharpening area, multiple white cutting boards, and the rim around the ice machine where the door seals.						
	d. The following non-food contact surfaces were soiled with food, dust, and kitchen debris: the shelving units above the food preparation table in the back of the kitchen and the food/dish carts located in the dry storage room.						
	e. The floor sink for the dishwashing machine was not properly draining because of the drain pipe placement.						
	f. A kitchen handwashing sink, located near the walk-in refrigerator, was not properly draining.  g. Multiple air vents, ceiling tiles, and wall junctures were soiled with dust, dirt, and debris throughout the kitchen and dry storage room.						
	Severity 2: Scope: 3	3					
Y 878 SS=D	449.2742(6)(a)(1) Me	edication / Change orde	r	Y 878			
	NAC 449.2742 6. Except as otherwis	se provided in this					

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	NVN2117AGZ			B. WING			/24/2011	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
			5165 SUMN RENO, NV	SUMMIT RIDGE CT , NV 89523				
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Y 878	Continued From page	e 3		Y 878				
	subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:  (a) The caregiver responsible for assisting in the administration of the medication shall:  (1) Comply with the order.							
	Based on record revi- the facility failed to er (Resident #1) receive prescribed. There wa Ester-C 500 milligram that had been admini milligrams daily.	ot met as evidenced by ew and interview on 1/2 nsure that 1 of 15 reside ed medications as as a physician's order to as daily. The medication stered was Ester-C 100 ficiency from the State	18/11, ents o give					
	Severity: 2 Scope: 1							
Y1035 SS=D	449.2768(1)(a)(1) De	mentia Training		Y1035				
	the administrator of a provides care to pers dementia shall ensure (a) Each employ direct contact with an with any form of dem	e that: ee of the facility who had d provides care to residentia, including, without aused by Alzheimer's	sh as dents					

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NAME OF D		NVN2117AGZ	STREET AND	RESS, CITY, STAT	re zip cone	01	/24/2011
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Y1035	035 Continued From page 4			Y1035			
	(1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer's disease, and providing support for the members of the resident's family.  This Regulation is not met as evidenced by: Based on record review on 1/18/11, the facility failed to ensure that a minimum of 2 hours of training related to the care of persons with dementia was received within the first 40 hours of work by 3 of 15 employees (Employees #4, #6 and #10).  Severity: 2 Scope: 1		ially ncy a, ease,				
			lity of urs of				
Y1036 SS=D	Y1036 SS=D 449.2768(1)(a)(2) Dementia Training			Y1036			
	the administrator of provides care to per dementia shall ensu (a) Each emplo direct contact with a with any form of der limitation, dementia disease, successfull (2) In addition to forth in subparagrap such an employee is facility, at least 8 ho	yee of the facility who hand provides care to resignentia, including, withou caused by Alzheimer's	eh dents t nts set fter e				

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Y1036	Continued From page 5			Y1036				
	including, without limitation, Alzheimer's disease.  This Regulation is not met as evidenced by: Based on record review on 1/18/11, the facility failed to ensure that a minimum of 8 hours of training related to the care of residents diagnosed with Alzheimer's was received within 90 days of hire by 3 of 15 caregivers (Employee #4, #6 and #10).  This was a repeat deficiency from the 1/19/10 State Licensure survey.							
	Severity: 2 Scope:	1						

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